

Roxborough
Memorial Hospital

5800 Ridge Avenue
Philadelphia, PA 19128

ROXBOROUGH MEMORIAL HOSPITAL

This information has been disclosed to you from records protected by Federal Confidentiality (42 CFR Part 2) and PA law. The Federal and State law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

AUTHORIZATION TO ACCESS/RELEASE PATIENT HEALTH INFORMATION

I hereby authorize Roxborough Memorial Hospital to release/obtain the following information from the health records of:

Patient Name: _____ DOB: _____ Age: _____ SS#: _____

Address: _____ Telephone No: _____

Patient Requests Access to the following information:

INFORMATION TO BE ACCESSED/RELEASED: (Include dates where appropriate)

Date(s) of Service _____

- | | | |
|---|---|---|
| <input type="checkbox"/> Inpatient Record | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Lab Reports |
| <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Short Procedure Record | <input type="checkbox"/> Consultation | <input type="checkbox"/> Psychiatric Evaluation |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Abstract of Record | <input type="checkbox"/> Treatment Plan |
| <input type="checkbox"/> Outpatient Psych Records | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Initial Evaluation |
| <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Facesheet | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Billing Record | <input type="checkbox"/> Other (Please Specify) _____ | |

Original films or pathology specimens (must complete reverse side of this form)

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I permit the following information to be released:

Behavioral or mental health HIV/AIDS Drug/Alcohol Genetic Testing

Patient Signature: _____ Date: _____

INFORMATION TO BE RELEASED TO/OBTAINED FROM: Please include name, full address & telephone #

FOR THE PURPOSE OF: Legal

INFORMATION RELEASED/OBTAINED VIA: Phone Fax US Mail Other

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise, revoked, this authorization will expire on the following date, event or condition: